DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		395614			00	12/28/2022		
ROLLING REHABILI	VIDER OR SUPPLIER: HILLS HEALTHCARE A ITATION CENTER	ND	STREET ADDRESS, CITY, STATE, ZIP CODE: 17350 OLD TURNPIKE ROAD MILLMONT, PA 17845					
	E NUMBER: 320202							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG			(X5) COMPLETE DATE	
E 0000	A COVID-19 Focused Survey was completed Health (DOH) on Dece Hills Healthcare and R facility was in complia related to E-0024 (b)(6	by The Department ember 28, 2022, at Rehabilitation Centernate with 42 CFR §4).	of olling . The 83.73	E 0000	TITLE:	(X6) DATE:		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

						-			
PLAN OF CORRECTION (POC) IDENT		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395614		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 12/28/2022			
NAME OF PRO	VIDER OR SUPPLIER:		STREET ADDRESS,						
	HILLS HEALTHCARE A	ND	17350 OLD TURNPIKE ROAD MILLMONT, PA 17845						
REHABILITATION CENTER			MILLMONT,	PA 17845					
STATE LICENSE NUMBER: 320202									
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE DATE					
F 0000	INITIAL COMMENT			F 0000					
	A COVID-19 Focused Infection Control Survey								
	conducted on December 28, 2022, at Rolling Hills								
	Healthcare and Rehabilitation Center, identified no								
	deficient practice. The facility was in compliance								
	with 42 CRF 483.80 Subpart B Requirements for								
	Long Term Care Facilities infection control								
	regulations and has implemented the CMS and								
	Centers for Disease Co		` ′						
	recommended practice		VID-19						
	and the 28 PA Code, C								
	Pennsylvania Long Ten	rm Care Licensure							
	Regulations as they rel	ate to the Health por	rtion of						
	the survey process.								

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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Certified End Page

ROLLING HILLS HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 320202 SURVEY EXIT DATE: 12/28/2022

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debia L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY